

## **PROCEDURES & SERVICES THAT DO NOT REQUIRE PRIOR AUTHORIZATION**

- ▶ This grid applies only to providers who participate with Arizona Priority Care.
- ▶ Prior Authorization is ALWAYS required for providers who are not in our network.
- ▶ Prior Authorization is ALWAYS required for elective inpatient admissions.
- ▶ Benefits and eligibility must ALWAYS be verified with the health plan.
- ▶ Failure to obtain prior authorization for procedures or services not on this grid may result in denial of coverage; as a result financial responsibility may be yours.
- ▶ This grid applies to all members; it is intended to be a guide and does not guarantee coverage or payment.
- ▶ Medical benefit plan language supersedes the general information provided on this grid.
- ▶ The presence or absence of an item on this list does not define whether or not coverage or benefits exist for the service or procedure and/or CPT Code.

SERVICE DESCRIPTION	CPT CODES
Abdominal Paracentesis	<b>49082-49083</b>
Administration of Chemotherapy** <i>**Coverage is subject to medical necessity and approval/authorization of drug</i>	<b>51720, 52287, 96365-96368, 96372-96375, 96401-96411, 96413-96417, 96450, 96521</b>
Annual depression screening	<b>G0444</b>
Aspiration and Steroid Injection of Joints (non-guided)	<b>20600, 20605, 20610</b>
Basic Wound Care	<b>12001-13153, 97602-97610, G0168</b>
Biopsies: lip, external ear, tongue	<b>40490, 41100, 41105, 69100</b>
Brief emotional/behavioral assessment	<b>96127, 96150-96152</b>
B-12 Injections	<b>96372, J3420</b>
Canes* <i>*Coverage is subject to medical necessity, based on CMS guidelines</i>	<b>E0100, E0105</b>
Chemical Cauterization of Granulation Tissue	<b>17250</b>
Chest Tube/Catheter	<b>32550-32552</b>
Commodes* <i>*Coverage is subject to medical necessity, based on CMS guidelines</i>	<b>E0163-E0168</b>
Compression Devices*	<b>E0650-E0675</b>

SERVICE DESCRIPTION	CPT CODES
*Coverage is subject to medical necessity, based on CMS guidelines*	
CPAP (Continuous Positive Airway Pressure) Device and Supplies*  *Coverage is subject to medical necessity, based on CMS guidelines	<b>E0601, A4604, A7027-A7046</b>
CPM (Continuous Passive Motion) Device; knee only*  *Coverage is subject to medical necessity, based on CMS guidelines	<b>E0935</b>
Crutches and Crutch Substitute*  *Coverage is subject to medical necessity, based on CMS guidelines	<b>E0110-E0118, E0153</b>
Decubitus Care Equipment*  *Coverage is subject to medical necessity, based on CMS guidelines	<b>E0181-E0191, E0196-E0199</b>
Destruction any method; malignant lesions	<b>17260-17286</b>
Destruction any method; premalignant lesions	<b>17000-17004</b>
Destruction any method; benign lesions ( <i>other than skin tags or cutaneous vascular proliferative lesions</i> )	<b>17110, 17111</b>
Diabetic Foot Care, Basic (diabetic shoes not included)	<b>G0127, G0245-G0247, 11719-11721, 11055-11057</b>
Diagnostic Anoscopies	<b>46600, 45300</b>
Dialysis Services	<b>90935-90940, 90945-90947, 90951-90970, 90999, Q4081</b>
Diffusing Capacity	<b>94729</b>
Dressings	<b>A6010-A6403, A6410-A6412, A6441-A6457</b>
DXA Scan	<b>77080-77086</b>
Ear Wax Removal	<b>69209, 69210, G0268</b>
ECG	<b>93000-93010, 93040-93042</b>
Enteral and Parenteral Nutrition and Supplies*  *Coverage is subject to medical necessity, based on CMS guidelines	<b>B4034-B4088, B4102-B4162, B4164-B5200, B9002-B9998</b>
Evaluation and Monitoring of Cardiovascular Devices	<b>93279-93299, 93724</b>
Excision of Chalazion (Meibomian Cyst)	<b>67800-67805</b>
External Cardiographic Recording (48 hours – 21 days)	<b>0295T-0298T</b>
Fine Need Aspiration without Imaging Guidance	<b>10021</b>
Foreign Body Removal	<b>10120, 10121, 24200, 65205, 69200</b>

SERVICE DESCRIPTION	CPT CODES
Fracture Management (confirmed, non-surgical) — Follow up X-ray, Initial & Follow up Office Visits, Splinting, Casting and Cast Removal	<b>29000-29750</b>
Ganglion Cyst Aspiration/Injection (non-guided)	<b>20612</b>
Gastric Suction Pump* <i>*Coverage is subject to medical necessity, based on CMS guidelines</i>	<b>E2000</b>
Glucose Monitoring by Subcutaneous Device* <i>*Physician fees only – actual device/monitor (K0553, K0554) requires prior authorization)</i>	<b>95249-95251</b>
Hemodialysis Insertion, Repair/De-clotting, and/or Removal of Dialysis Catheter	<b>36831-36833, 36860-36861, 36593, 36589-36590, 36800-36821</b>
Home Visits by a PCP	<b>99324-99337, G0179-G0180</b>
Humidifiers/Compressors/Nebulizers* <i>*Coverage is subject to medical necessity, based on CMS guidelines</i>	<b>E0560-E0585</b>
Incision and Drainage	<b>10060-10061, 10080-10081, 10140, 10160, 10180, 26010-26034, 46050</b>
Incision/Excision of Thrombosed External Hemorrhoids	<b>46320, 46083</b>
Incontinence Supplies * <i>*Coverage is subject to medical necessity, based on CMS guidelines</i>	<b>A4310-A4360, A5102-A5200</b>
Infusion Port-a-Cath, or Power-Ports (central line access catheters ) including Insertion, Removal, Repair and Catheter Care	<b>36595-36596, 36555-36571, 36575-36590</b>
Ingrown Toenail Removal, Biopsy, Repair	<b>11730, 11732, 11740, 11750, 11755, 11760, 11765</b>
Inhalation Treatments	<b>94640, 94644-94645, 94664</b>
Injection of Tendon Sheaths, Bursa and Trigger Points (non-guided)	<b>20526-20553, 20600, 20605, 20610</b>
In Office Injections: <i>Toradol, Benadryl, Dexamethasone, Phenergan, Carbocaine, Depo-Medrol, Marcaine, betamethasone acetate/sodium phosphate, Kenalog, furosemide, midazolam, alteplase recombinant, bupivacaine</i>	<b>J1885, J1200, J1100, J2550, J0670, J1030, J2930, J3490, J0702, J3301, J1940, J2250, J2997, S0020</b>
INR Monitoring	<b>93792-93793, G0250, 85610</b>
Instillation Drug/Chemical by Chest Tube	<b>32560-32562</b>
Intraperitoneal Catheter Insertion and Removal	<b>49418, 49422</b>
Intrathoracic Placement Radiation Therapy Devices	<b>32553</b>
IV Hydration—Normal saline, D5W and/or LR	<b>96360, 96361, J7030, J7040, J7050</b>

SERVICE DESCRIPTION	CPT CODES
Mammography and Breast Tomosynthesis	<b>77061-77067, G0279</b>
Manual Wheelchairs, Manual Wheelchair Accessories, and Wheelchair Cushions*  <i>*Coverage is subject to medical necessity, based on CMS guidelines</i>	<b>E0958-E0960, E0971, E0974-E0982, E0990-E0995, E1015, E1017, E1020-E1030, E1050-E1228, E1231-E1238, E1240, E1270, E1280, E1295-E1298, E2201-E2295, E2601-E2608, E2611-E2616, E2619-E2625, E2626-E2633, K0001-K0007, K0015-K0077, K0105, K0195</b>
Marsupialization of Bartholin’s Cyst	<b>56440</b>
Measurement of post voiding residual urine and/or bladder capacity by ultrasound, non-imaging	<b>51798</b>
Medical Nutrition Therapy Services**  <i>**diagnosis of renal disease or diabetes <u>ONLY</u></i>	<b>97802-97804, G0270</b>
Negative Pressure Wound Therapy (Wound Vac) and Supplies*  <i>*Coverage is subject to medical necessity, based on CMS guidelines</i>	<b>E2402, A6550, A7000</b>
Nitric Oxide Expired Gas Determination	<b>95012</b>
Non-invasive Vascular Studies: extremities	<b>93922-93924</b>
Occipital Nerve Block	<b>64405</b>
Office Visits	<b>99201-99215</b>
Ophthalmology Exam and Evaluation	<b>92002-92014</b>
Orthopedic Devices*  <i>*Coverage is subject to medical necessity, based on CMS guidelines</i>	<b>E0910-E0930, E0940-E0948</b>
Osteopathic Manipulative Treatment (OMT)	<b>98925-98929</b>
Ostomy Pouches and Supplies*  <i>*Coverage is subject to medical necessity, based on CMS guidelines</i>	<b>A4361-A4435, A5051-A5093</b>
Outpatient PT/OT/ST— Initial Evaluation and 1 (one) Treatment ( <i>free standing facility only</i> )	<b>97161-97163, 97165-97167, 92521-92523</b>

SERVICE DESCRIPTION	CPT CODES
Oxygen and Respiratory Equipment and Supplies* <i>*Coverage is subject to medical necessity, based on CMS guidelines</i>	<b>A4614-A4626, A4628-A4629, A7001-A7018, A7047            E0424-E0445, E0466-E0480, E0482-E0484, E0600, E1353-E1355, E1372, E1390-E1392, K0738, K0739</b>
Patient Lifts* <i>*Coverage is subject to medical necessity, based on CMS guidelines</i>	<b>E0621, E0630, E0635</b>
Percutaneous Drainage	<b>75984, 75989</b>
Plain Film X-Ray	<b>70030-70160, 70190-70330, 70360-70370, 70380, 71045-71130, 72020-72120, 72170-72190, 72200-72220, 73300-73030, 73050-73080, 73090-73110, 731120-73140, 73501-73523, 73560-73565, 73590-73660, 74018-74022, 74210-74220, 76000-76001, 76080-76098, 77074-77075</b>
Plethysmography for Lung Volume	<b>94726</b>
Pleural Aspiration and Drainage	<b>32554-32557</b>
PPD Tuberculosis Test	<b>86580</b>
Prostate Screenings	<b>G0102</b>
Pulmonary Stress Test, simple	<b>94618</b>
Pulse Oximetry	<b>94760, 94761</b>
Removal of Foreign Substance and Infected/Devitalized Tissue	<b>11000-11012</b>
Routine Medicare-covered Vaccinations	<b>90630, 90653-90658, 90660-90662, 90670, 90672-90674, 90682, 90685-90688, 90732, 90739, 90740, 90743, 90744, 90746, 90747, 90756, G0008-G0010, Q2034-Q2039</b>
Shave, Punch or Excisional Skin Biopsies	<b>11102-11107, 11300-11313, 11400-11446</b>
Skin Lesion removal; confirmed malignant	<b>11600-11646</b>
Smoking and Tobacco Cessation Counseling	<b>99406-99407</b>

SERVICE DESCRIPTION	CPT CODES
Spinal Manipulation	98940, 98941, 98942
Spirometry Test	94010, 94060
TENS (Transcutaneous Electrical Nerve Stimulation) device* <i>*Coverage is subject to medical necessity, based on CMS guidelines</i>	E0720-E0730, A4556-A4557, A5695
Tracheostomy Supplies and Speaking Valve* <i>*Coverage is subject to medical necessity, based on CMS guidelines</i>	A4605, A4608, A4481, A7501-A7527, L8501
Transfer Bench/Device* <i>*Coverage is subject to medical necessity, based on CMS guidelines</i>	E0247, E0248, E0705
Treatment of Genital Warts	56501, 56515, 57061, 57065, 54050-54065
Treatment of hidradenitis; excision and repair	11450-11471
Treatment of Lesions; injection	11900-11901
Ultrasound	76506, 76510-76529, 76536-76800, 76801-76802, 76805-76819, 76830-76873, 76881-76882, 76975, 76977
Ultrasound Guidance for Needle Placement and Vascular Access	76942, 76937
Urinary Catheterization (insertion/removal)	51701-51703, A4351, A4358
Vein Mapping for Fistula	93970, 93971
Walkers* <i>*Coverage is subject to medical necessity, based on CMS guidelines</i>	E0130-E0149, E0154-E0159
<b><u>For OB/Gyn Specialists Only:</u></b> In-Office GYN Procedures: Endometrial Biopsies, Colposcopies with Biopsy	58100, 58110, 58555, 58558, 57420-57421, 57452-57461, 56820, 56821, G0123-G0124, Q0091, Q0111
<b><u>For ENT Specialists Only:</u></b> Control of Nosebleed, Nasal Endoscopy Dx, Nasal/Sinus Endoscopy Surg, Diagnostic Laryngoscopy, Diagnostic Laryngoscopy, Ear Microscopy Examination, Basic Vestibular Evaluation, Spontaneous Nystagmus Test	30901-30903, 30905, 30906, 31231, 31237, 31505, 31575, 92504, 92540, 92541
<b><u>For ENT &amp; Audiology Specialists Only:</u></b> Tympanometry & Reflex Threshold, Pure Tone Audiometry Air, Audiometry Air and Bone, Speech Threshold Audiometry, Speech Audiometry Complete, Comprehensive Hearing Test, Tympanometry, Acoustic Reflex Threshold Test	92550, 92552, 92553, 92555, 92556, 92557, 92567, 92568

SERVICE DESCRIPTION	CPT CODES
<p><b><u>In-Office Laboratory Services:</u></b>  Collection of venous blood venipuncture, Urinalysis, non-automated without microscopy, Glucose, serum glucose monitoring device(s) cleared by the FDA specifically for home use, Heterophile antibodies—screening, Tuberculosis, intradermal, Urine pregnancy test, by visual color comparison methods, Infectious agent enzymatic activity other than virus (e.g., sialidase activity in vaginal fluid)</p> <p>Detection Infectious Agent by Immunoassay with Direct Optical Observation</p>	<p><b>36410, 36415, 81000-81003, 82962, 86308, 86580, 81025, 87905</b></p> <p><b>87804, 87807, 87808, 87809, 87880</b></p>
<p><b><u>Office-based Mental Health/Behavioral Health Services*:</u></b></p> <p><i>*Please note Services that require prior authorization include, but are not limited to: Trans Magnetic Stimulation (TMS), Electro Convulsion Therapy (ECT), Intensive Outpatient Treatment (IOP), Partial Hospitalization (PHP), treatment for autism, treatment for eating disorders, or services associated with substance abuse such as detoxification, rehabilitation, or medication assisted treatment (MAT).</i></p> <p><i>*Services must be provided by a: licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health professional as allowed under applicable state laws</i></p>	<p><b>All</b></p>
<p><b><u>Chiropractic Services*</u></b></p> <p><i>*Coverage is limited to the enrollee’s benefit plan and visit limitations</i></p>	<p><b>All</b></p>
<p><b><u>East Valley Access Center</u></b></p>	<p><b>All</b></p>
<p><b><u>In Network Laboratory Services</u></b></p>	<p><b>All</b></p>
<p><b><u>Unique Labs*</u></b></p> <p><i>*Homebound members ONLY</i></p>	<p><b>All</b></p>